IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
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E-mail: fsb@idhw.state.id.us

August 3, 2009

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

RE: Idaho State School And Hospital, provider #13G001

Dear Ms. Broetje:

This is to advise you of the findings of the complaint survey of Idaho State School And Hospital, which was conducted on July 29, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 17, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by August 17, 2009. If a request for informal dispute resolution is received after August 17, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MATT HAUSER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw

Enclosures

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

Susan Broetje – Administrative Director
IDAHO STATE SCHOOL AND HOSPITAL
Idaho State Developmental Center
1660 11TH Avenue North
Nampa, Idaho 83687-5000
PHONE 208-442-2812
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August 11, 2009

Debby Ransom, R.N., R.H.I.T.
Bureau Chief
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

Re: Idaho State School and Hospital, Provider #13G001

Dear Ms. Ransom:

Enclosed you will find the Plan or Correction for W112, W148, W154, W155 and the applicable state referral tags which were cited during the complaint survey on July 29, 2009.

If you have any questions, please call me at 442-2812. Thank you.

Sincerely,

SBroetje

Susan Broetje
Administrative Director
Idaho State School and Hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING _____ B. WING _____	C 07/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey. The survey was conducted by: Matt Hauser, QMRP, Team Lead Monica Williams, QMRP Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: AOD - Administrator On Duty QMRP - Qualified Mental Retardation Professional	W 000	RECEIVED AUG 13 2009 FACILITY STANDARDS	
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all information was kept confidential for 31 of 31 individuals (Individuals #4, #5, #7 - #9, and #11 - #36) whose full names were noted to be posed outside their bedrooms and whose records were unsecured. This resulted in individuals' information being available to other individuals, visitors, and non-staff. The findings include: 1. During an observation on a living unit on 7/28/09 at 10:30 a.m., it was noted that each individual's full name was printed on a placard which was located outside their respective bedrooms. When asked, the QMRP, who was present during	W 112		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

S Broetje ADMINISTRATIVE DIRECTOR 8/11/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 112	Continued From page 1 the observation, stated he also created a floor map. The QMRP proceeded to show the survey team a floor map that was posted on the wall behind the unit front desk. The floor map contained each individual's full name. The QMRP stated the map was created so that substitute staff, not familiar with the individuals, would know the location of each individual's bedroom. Further, upon entering a second unit the morning of 7/29/09 at 8:05 a.m., the door to the record room, which contained individuals' medical and program records, was noted to be propped open. A non-staff person was mopping the floor nearby. When asked, he stated there was a staff person there but she had left about five minutes ago. No staff person was noted to come to the room and the survey team locked the door at 8:20 a.m. The facility failed to ensure individuals' full names and records were kept in a confidential manner.	W 112		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on review of the facility's behavior reporting policy, team investigations, and staff interviews it was determined the facility failed to ensure significant events were promptly reported to guardians for 2 of 3 individuals (Individuals #11 and #12) who engaged in sexual misconduct. This resulted in a lack of advocacy for individuals	W 148		

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W 148	Continued From page 2 by the legal guardian. The findings include: 1. The facility's Client Behavior and Incident Reporting policy, dated 7/21/09, stated nursing staff were to contact individuals' guardians of significant events including sexual behavior, defined as sexual behavior between individuals residing at the facility. The policy stated contact was to be completed the same shift. a. A Team Investigation and Action Plan, dated 7/6/09, stated Individual #11 reported he engaged in consensual sex with Individual #13 on 6/30/09. Attached documentation stated Individual #11's guardian was not contacted until 7/9/09. The documentation stated Individual #13 was his own guardian. b. A Team Investigation and Action Plan, dated 7/24/09, stated Individual #12 and Individual #13 had been found by staff engaged in "inappropriate oral sex" on 7/19/09. Attached documentation stated Individual #12's guardian was not contacted until 7/24/09. When asked during an interview on 7/29/09 from 8:55 - 10:00 a.m., the QMRP stated guardians for Individual #11 and Individual #12 had not been contacted about the events due to an oversight. The Ancillary Services Manager, who was present during the interview, stated the guardians should have been contacted at the time of the incident. The facility failed to ensure Individual #11 and Individual #12's guardians were promptly notified of significant events.	W 148		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS	W 154		

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W 154	Continued From page 3 The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure thorough investigations were conducted for 3 of 3 individuals (Individuals #11, #12, and #13) who engaged in sexual misconduct. This resulted in a lack of sufficient information being available on which to base corrective action decisions. The findings include: 1. A Team Investigation and Action Plan, dated 7/6/09, stated Individual #11 reported he engaged in sexual misconduct with Individual #13 on 6/30/09. The Team Investigation and Action Plan did not include evidence of a thorough investigation as follows: a. The Team Investigation and Action Plan stated Individual #13 was noted to be missing at 5:00 p.m. Individual #13 was found in Individual #11's bedroom at 5:05 p.m. Individual #13 stated he had been in Individual #11's bedroom since 4:20 p.m. Written statements from five staff were attached to the Team Investigation and Action Plan. One staff documented Individual #13 had been seen going out to smoke at 4:40 p.m. The same staff documented she had entered the kitchen shortly after seeing Individual #13, and it was "4:40 ish." It was not clear how long after seeing Individual #13, the staff walked into the kitchen. None of the other four staff documented any information regarding Individual #13's whereabouts, prior to being found missing at 5:00 p.m., until the time he	W 154		

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W 154	Continued From page 4 was found at 5:05 p.m. When asked during an interview on 7/29/09 from 8:55 - 10:00 a.m., the QMRP stated he had not interviewed the staff, who provided the written statements, to clarify the information documented or determine why there was a discrepancy in time reported by Individual #13 and the staff (4:20 p.m. versus 4:40 p.m.). b. The Team Investigation and Action Plan stated Individual #13 was interviewed by the Sex Offender Coordinator on 1/7/09 and disclosed he and Individual #11 had engaged in sexual activity in Individual #11's bedroom 1 - 2 times per month for about one year. Individual #13 stated the activity included anal sex, oral sex, mutual fondling, and kissing. Individual #13 stated he and Individual #11 would plan to get together and would wait for times when the staff was busy dealing with other individuals on the unit. The Team Investigation and Action Plan did not include documentation that the reported on-going contact had been investigated. When asked during an interview on 7/29/09 from 8:55 - 10:00 a.m., the QMRP stated the interview with the Sex Offender Coordinator had occurred on 7/1/09 rather than 1/7/09. The QMRP stated he was not sure if the on-going contact between Individual #11 and Individual #13 was occurring at the time of disclosure because he had not looked into the allegation. The QMRP stated he focused only on the 6/30/09 incident. The facility failed to ensure all discrepancies, as well as new allegations made, were investigated for the 6/30/09 incident.	W 154		

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W 154	Continued From page 5 2. A Team Investigation and Action Plan, dated 7/24/09, stated staff found Individual #12 and Individual #13 engaged in "inappropriate oral sex" on 7/19/09 at the dumpster area behind the unit. Individual #12 and Individual #13 planned and left the unit from different exits in order to meet and engage in sexual misconduct. The Team Investigation and Action Plan stated staff discovered the individuals missing during 15 minute checks and immediately located the individuals and separated them. Attached to the Team Investigation and Action Plan was a Report of Client Event form, completed by the AOD, regarding the incident. The Report of Client Event form documented the individuals had been gone for 15 to 30 minutes before staff found them. However, the Report of Client Event form also documented the incident was reported at 8:36 p.m. and the individuals were found at 10:30 p.m. The Team Investigation and Action Plan did not address the discrepancy in time the individuals were missing (i.e., immediately found, 15 to 30 minutes missing, or 2 hours missing). Additionally, how Individual #12 and Individual #13 were able to exit from two different locations, and meet without staff's knowledge or being witnessed was not addressed. When asked during an interview on 7/29/09 from 8:55 - 10:00 a.m., the QMRP stated he was not aware of the discrepancies in time and it had not been investigated. The QMRP stated he was not aware of how Individual #12 and Individual #13 were able to arrange and follow through with the event and had not looked into that issue.	W 154		

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W 154	Continued From page 6 The facility failed to ensure the 7/19/09 incident was thoroughly investigated.	W 154		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on review of team investigations and staff interviews, it was determined the facility failed to ensure potential abuse was prevented while an investigation was in process for 2 of 3 individuals (Individuals #11 and #13) who engaged in sexual misconduct. This resulted in a lack of measures to prevent further misconduct being taken until the investigation was completed. The findings include: 1. A Team Investigation and Action Plan, completed 7/6/09, stated Individual #11 reported he engaged in sexual activity with Individual #13 on 6/30/09. The Team Investigation and Action Plan stated "The team has reviewed all the data and decided that moving [Individual #11] to a different room on a separate hall on the same unit would provide for immediate protection." However, the investigation did not document when the room change occurred. During an interview on 7/29/09 from 8:55 - 10:00 a.m., the QMRP stated he was not sure when Individual #11's room change occurred, but believed it was on 7/6/09 or 7/9/09. The QMRP stated no additional protective action had been implemented to ensure protection of both Individual #11 and Individual #13 during the	W 155		

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W 155	Continued From page 7 course of the investigation. Following the interview on 7/29/09, the QMRP provided documentation that Individual #11's room change occurred on 7/6/09. The facility failed to ensure immediate measures were taken to prevent further sexual misconduct between Individual #11 and Individual #13.	W 155		

Bureau of Facility Standards

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W154 and W155.	MM177	RECEIVED AUG 13 2009 FACILITY STANDARDS	
MM199	16.03.11.075.11 Assurance of Confidentiality Assurance of Confidentiality. Each resident admitted to the facility must be assured confidential treatment of his personal and medical records, and must be permitted to approve or refuse their release to any individual outside the facility except: This Rule is not met as evidenced by: Refer to W112.	MM199		
MM231	16.03.11.080.03(a) Informed of Activities To be informed of activities related to the resident that may be of interest to them or of significant changes in the resident's condition; and This Rule is not met as evidenced by: Refer to W148.	MM231		

Bureau of Facility Standards

S Bloedge ADMINISTRATIVE DIRECTOR 8/11/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Attachment for FORM CMS-2567, 7/29/09 Survey
Idaho State School and Hospital

TAG #: W112

1. Corrective action for the identified problem.

The CSU changed all of the name tags for full names were not posted. This was a new QMRP who did not realize the client full names should not be posted.

All staff will be reminded of the need to keep record rooms locked when not in use. The housekeeping supervisor will inform his team that CWC workers are not to clean in areas where confidential information is stored without direct visual supervision.

2. Discipline responsible for monitoring system changes for maintenance of compliance.

P.I. Department will look for this when doing routine review activities on the buildings. QMRPs will be responsible to take corrective action if staff post confidential items in public view.

3. Date when correction action will be corrected (usually within 60 days):

Name plate changes completed on 7/29/09.
All steps completed 8/28/09.

TAG #: W148

1. Corrective action for the identified problem.

Nursing staff, social workers, and QMRPs will be retrained in guardian notification expectations.

2. Discipline responsible for monitoring system changes for maintenance of compliance.

The Assistant Administrator will ensure notifications are made if not documented on the 7055B form and will notify the Administrator of issues so that corrective action can be taken.

3. Date when correction action will be corrected (usually within 60 days):

8/28/09

TAG #: W154 and W155

1. Corrective action for the identified problem.

The facility's PI Supervisor and Abuse Investigator will train the QMRPs and the Assistant Administrator in techniques of thorough investigations for significant event and in appropriate corrective action to ensure client protection. AODs will be included in the training to ensure that they prompt adequate protective action.

2. Discipline responsible for monitoring system changes for maintenance of compliance.

The Assistant Administrator will ensure significant event investigations are thorough and that client protections are in place as needed. The Assistant Administrator will notify the Administrator when correction action is needed.

3. Date when correction action will be corrected (usually within 60 days):

9/15/09

ATTACHMENT FOR STATE SURVEY FORM: 7/29/09 SURVEY
Idaho State School and Hospital

MM177
Refer to W154 and W155

MM199
Refer to W112

MM231
Refer to W148

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3232 Elder Street
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Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 3, 2009

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **July 29, 2009**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004193

Allegation #1: Individuals' behaviors are not being documented due to changes in definitions in policy and procedures.

Findings: An unannounced onsite complaint investigation was conducted from 7/27/09 - 7/29/09. During that time, review of the facility's behavior reporting policy, observations, record review, and individual and staff interviews were conducted with the following results:

The facility's Client Behavior and Incident Reporting Policy and Procedure, dated 7/21/09, was reviewed and compared with the previous version, dated 5/21/09. The 7/21/09 policy contained the following changes:
- One sentence had a font change to italics.
- One sentence had been added to clarify attempted injury to self.
- The supervisor review prior to the end of the shift and signature was removed.
- The Clinician/Psych Tech section deleted 2 steps (a check for completion and sending a copy to the applicable supervisor) from the procedure.

The policy revisions did not include changes to behavioral definitions but rather clarified the definition of attempted self injury.

Observations were conducted throughout the survey for a cumulative of 7 hours 30 minutes. During that time, two individuals were noted to engage in maladaptive behaviors. Staff were noted to document the behaviors on a Behavior Reporting Forms (BRF).

The BRF included a standardized list of maladaptive behaviors including assault, destruction of property, elopement, sexual behavior, and suicide threats. The BRF included an area for new or emerging behaviors and individuals' target maladaptive behaviors as well. The back page of the BRF included space to document antecedents (what happened before the behavior), the behavior (what the staff saw and heard), and the consequence (staff interventions).

Twenty three (23) direct care staff were interview during the course of the survey. When asked, all staff reported they used the BRF to document all behaviors. When asked where to document a new maladaptive behavior that was not specified on the BRF, all staff stated they would document the behavior on the back of the form in a narrative format.

Ten individuals' records were selected for review. Their Behavior Reporting Forms (BRFs) contained documentation of their target behaviors and emerging behaviors. Additionally, one individual's record contained documentation that housekeeping staff identified the individual had urinated on the floor in his private bathroom. As a result, the facility initiated a tracking system of the behavior.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals' maladaptive behaviors are increasing and medications are being increased prior to less restrictive interventions being attempted.

Findings: An unannounced onsite complaint investigation was conducted from 7/27/09 - 7/29/09. During that time observations, record review, and staff interviews were conducted with the following results:

Observations were conducted throughout the survey for a cumulative of 7 hours 30 minutes. During that time, two individuals were noted to engage in maladaptive behaviors. Staff were noted to physically step between the individuals and verbally redirect them to calming activities.

Ten individuals' records were selected for review. For those ten individuals, Behavior Reporting Forms (BRFs) were reviewed and compared to their Psychoactive Drug Review notes. That comparison documented the majority of medication changes were made based on individuals' health status. For example, an individual's Inderal (an antianginal drug) was increased due to the individual being recently diagnosed with bradycardia (a condition in which the heart rate is slower than normal).

Additionally, behavioral data was reviewed from 4/09 - 7/14/09 for individuals who most frequently engaged in maladaptive behaviors. The data showed individuals' maladaptive behaviors were decreasing. Further, the individuals' Psychoactive Drug Review notes where reviewed for the same time frame and showed behavior modifying drugs were being decreased.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Requests for records are not being honored.

Findings: An unannounced onsite complaint investigation was conducted from 7/27/09 - 7/29/09. During that time, record review and staff interviews were conducted with the following results:

Records Department staff were interviewed on 7/28/09 at 9:15 a.m. When asked about the process of obtaining records, the staff person stated all requests for records were honored within 3 working days. The staff person stated specific records were routinely sent annually or more frequently if requested by parents or guardians. The staff person stated two guardians currently received more frequent information per their requests.

When asked how long records were maintained, the staff person stated all records were maintained in their original form, from admission to 7 years after a person was discharged from the facility. At that time, records were transferred to a microfiche or an electronic form.

When asked about recent requests for records, the staff person stated he had one request for information dating back to the 1920's and one request for information from the 1990's. the staff person stated the 1990's request was cancelled by the guardian as the information was discussed in a recent team meeting.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Transfer agreements are not being honored.

Findings: An unannounced onsite complaint investigation was conducted from 7/27/09 - 7/29/09. During that time, record review and individual interviews were conducted with the following results:

Ten individuals records were selected for review. Of those ten, one individual's record showed he was transferred to another living unit on 2/01/09. The individual's record documented if the transfer did not work out, the individual would be able to return to his previous living unit. The individual's record documented the team would evaluate this progress based on his maladaptive behavior. The record documented the individual was stable and the transfer was working out.

The individual was interviewed on 7/28/09 from 5:24 - 5:35 p.m. When asked, the individual stated the transfer to the new unit was going "real well," though at times, had been difficult. The individual stated the new unit was an improvement from the previous unit and the individual did not want to move.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MATT HAUSER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw